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OFFICE OF INSPECTOR GENERAL

**Application for License to
Operate a Long-term Care Facility**

For Office Use Only

Received 10/31/11Amount 1800.00

#080627

I. IDENTIFICATION

Name

Gallatin Health Care, LLC

Address

P.O. Box 968

City/County/Zip

Warsaw, KY 41095

Telephone number

(859) 567-4548

Administrator

Stacie Darnold

Date facility operation began at current address

1990

Date facility began operation under current owner

1990**II. TYPE BEDS**

No. beds licensed

No. beds requested

Skilled

Nursing Home

Nursing Facility

Intermediate Care

ICF/MR

Personal Care

120**II. CONTROL (check one in each column)**

State

County

City

☒ Private☒ Profit

Nonprofit

Individual

Partnership

☒ Corporation**II. OWNERSHIP**

Name and address of individual owner, partners or corporation. If partnership, list partners.

Gallatin HealthCare, LLCc/o Loudens * Co, LLC (Direct Owner)3147 Creston Drive, Suite ALexington, KY 40517

(OVER)

✓

If facility owned or leased by a corporation, complete the following:

Name of corporation Gallatin Health Care, LLC
Address of corporation 3147 Custer Dr. Lexington, KY
President or Chairman Mark Bowman, President / Russell Louden, Chairman
Vice President Joan Louden & Richard Slukich
Secretary Mark Bowman
Treasurer Richard Slukich

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent
Louden & Co, LLC
3147 Custer Dr, Suite A
Lexington, KY 40517

Management Company
N/A

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Mark W. Damsel
Signature of authorized representative

Administrator 10/21/11
Title Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)